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ABSTRACT

A study was conducted to explore the relationship between socioeconomic and personal circumstances of women in health occupations and their labor market behavior. Using a conceptual framework (the Life Patterning Process), discussions were held in six states with a total of 279 women representing five health occupations: registered nurses, licensed practical nurses, dentists, dental hygienists, and health care administrators. The discussions centered on the interrelationships of childhood socioeconomic status, marriage, childbearing, career development, and job satisfaction. Additionally, employment benefits provided by hospitals, nursing homes, and dental group practices were studied. Major conclusions and recommendations include the following: (1) women in health occupations are increasingly combining a career with marriage and a family, a pattern which differs markedly from prevailing social norms; (2) job benefits must be redesigned to meet the needs of working women and to include those engaged in part-time work; (3) the most critical factors in initial career choice are the attitudes of parents and guidance counselors; (4) flexible scheduling should be considered for jobs in the health fields; (5) career advancement projects should be undertaken by single or related health care institutions; and (6) national legislation on health manpower, cost control, and occupational health and safety should be studied by groups representative of women's interests. (ELG)

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EXECUTIVE SUMMARY

A Study of The Participation of Women in The Health Care Industry Labor Force

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EXECUTIVE SUMMARY

A STUDY OF THE PARTICIPATION OF WOMEN IN THE HEALTH CARE INDUSTRY LABOR FORCE

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The opinions and conclusions expressed in this report are those of the project staff and do not necessarily represent those of the Radcliffe College or the Department of Health, Education, and Welfare.

INTRODUCTION

The provision of health care service accounts for a sizeable proportion of total employment in the United States. According to the National Center for Health Statistics, approximately 4,700,000 people were employed in the health care industry in 1974;[1] fully 75 percent of these employees were women.[2]

Health occupations and professions in the United States manifest clear evidence of sex-typing. Doctors, dentists, and pharmacists are commonly assumed to be male; females are expected to elect such auxiliary occupations as nursing and dental hygiene. Reality still largely coincides with such assumptions.[3]

The women's movement and recent supportive legislation have both enhanced some women's occupational options and career mobility. The advent of affirmative action has resulted in increases in the numbers of women entering such traditionally male professions as medicine, law, and dentistry.

Nevertheless, the majority of women select and continue to pursue traditionally female occupations and roles. And most employed women, whatever their occupations, must struggle with conflicts between family obligations, personal desires and ambitions, and the demands and limitations of their work.

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1 U.S. Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics, Health Resources Statistics, (Washington, D.C.: Government Printing Office, 1976), p. 9.

2 Maryland Pennell and Shirlene Stowell, Women in Health Careers, Chart Book for the International Conference on Women in Health, June 1975 (Washington, D.C.: American Public Health Association, 1975), Table 4. The percentage of women in the health labor force may be variously calculated, depending on the number and types of occupations included. The figure stated above, 75 percent, represents only occupations directly engaged in the delivery of health services. If employees of third-party payor groups and the drug industry were included, female clerical and pink-collar employees would probably increase the total proportion of females to 80 percent. According to the source cited above, the percentage of women in the health labor force has increased by 5 percent per decade since 1950; projecting the 1970 figures to 1977, the total proportion of women in the health labor force may be estimated at close to 85 percent.

3 Eugenia S. Carpenter, "Women in Male-Dominated Health Professions," International Journal of Health Services 7, no. 2 (1977): 191-207.

The purpose of the research reported here was to explore the relationship between the socioeconomic and personal circumstances of women in the health care labor force and their labor market behavior. Specifically, this report examines this relationship in the lives of women employed in five health care occupations.[4]

During negotiations on the contract funding this study, the original mandate was expanded to allow for a study of employers' practices with regard to the provision of benefits. In keeping with the exploratory nature of the study as a whole, this portion of the report should be considered only suggestive in nature.

The major activities of the study were as follows:

1. Selection of the specific populations of health employees to be studied.

2. Background research to identify barriers and enabling factors related to women's choices of health occupations.

3. Development of the Life Patterning Process.

4. Development of a questionnaire and study design based on research and on the Life Patterning Process.

5. Collection of opinions and accounts of personal experiences relevant to the Life Patterning Process from women employed in selected health occupations. This information was collected in group discussions.

6. Development of conclusions and recommendations for future research and policies pertaining to health manpower.

Certain of the study's limits should be noted. Although intensive efforts were made to include a high proportion of minority women, only 48 of the 279 participants in group consultations were nonwhite. For this reason, the findings probably reflect the circumstances of white women health employees more accurately than those of minorities. Furthermore, due to the exploratory nature of the study, specific facts about each of the participants in the

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4 The project was originally mandated to study four groups: licensed practical nurses, registered nurses, dental hygienists, and dentists. As the project proceeded, however, health care administrators emerged as interesting and instructive for comparative purposes, and were subsequently added.

group consultations were not available; thus it was impossible to aggregate and compare certain pieces of information that would have contributed usefully to the development of the final hypotheses and conclusions. The study explores the problems faced by a cross-section of women in the health labor force hierarchy. It is hoped that future studies will draw on the materials and hypotheses presented here in order to enhance the existing body of knowledge on sex-stereotyping in health care. It is also hoped that those responsible for health manpower planning will recognize the critical importance of women in the health labor force and will design benefits and working conditions to maximize women's participation in this vital sector of the American economy.

The findings of the study are presented in the four chapters of this report and its two appendices.

A STUDY OF THE PARTICIPATION OF WOMEN IN THE HEALTH CARE INDUSTRY LABOR FORCE

ABSTRACT

Exploratory in design, this research seeks to identify the barriers and facilitators to women employed in health occupations. Using a conceptual framework (The Life Patterning Process) as a guide, interrelationships among childhood socioeconomic status, marriage, childbearing, career development, and job satisfaction were discussed with women located in six states: Georgia, Massachusetts, Minnesota, Ohio, Texas, and Washington. In these states, groups of women representing each of five health occupations were brought together for the discussion process; occupations included registered nurses (RNs), licensed practical nurses (LPNs), dentists, dental hygienists, and health care administrators. Additionally, employment benefits provided by hospitals, nursing homes, and dental group practices were studied. Major conclusions of the study are: existing and future health manpower legislation must be reviewed to determine its impact on women trained but not presently in the health labor market, women currently participating in the health labor market, and those planning to enter; initial career choice is a major determinant of future career options (in order to expand options, specific attention must be given to the design and content of continuing education programs for persons trained in specific health occupations); job benefits need to be redesigned to meet the needs of working women and to more fully include those employed less than full time. Further research recommendations are made.

METHODOLOGY

1. Employment Patterns Study

A series of consultations with women health workers was deemed a potentially productive and expeditious means of gathering information on factors affecting women's participation in the health care labor force. In-depth oral descriptions of women's own experiences seemed likely to provide for the rich and suggestive data appropriate to an exploratory study of this nature. The initial goal was to contact and interview groups of women to yield a substantial, if subjective, body of information of sufficient variety to ensure the representation of many points of view.

The five occupations selected for investigation -- licensed practical nurses, registered nurses, dental hygienists, dentists, and health care administrators -- were chosen to ensure participation by low- and high-status health workers employed in both traditionally male and female occupations. In an effort to provide for regional and ethnic diversity, six states were chosen as sites for group consultations: Massachusetts, Ohio, Georgia, Texas, Washington, and Minnesota.

a. Implementation of the Consultations. Letters of inquiry to OHRO Regional Coordinators for Women and Health in the five regions serving the six selected states led to the development of personal referral networks through which potential participants were contacted. A format was devised for a two-hour taped consultation session involving six to eight women; special consideration was given to maximizing participants'

willingness to discuss their experiences and to maintaining complete confidentiality. Each session was to be attended by members of a single occupational group.

A discussion guide outlining potential topics of discussion was developed to facilitate the consultations; often, participants wrote specific information about themselves on their guides. An initial series of consultations in Massachusetts was undertaken to test the format and draft materials.

Project staff made a preliminary round of travel to each of the five remaining states. These visits secured the confidence and support of key contacts who served as important links in the referral networks and provided information necessary to schedule and implement the consultations. Visits were also made to the annual meetings of the American Public Health Association and the American Dental Association; both yielded valuable referrals.

A schedule was devised for all consultation sessions outside of Massachusetts. Potential participants' names and addresses were assembled and invitations were issued according to a schedule allowing a minimum of one month to respond prior to the meeting.

Sessions were held at the convenience of the majority of potential participants; telephone confirmations were made prior to each meeting. The format of the meetings was relatively unstructured. After asking the participants to describe the routes they had followed to their present positions, the project staff allowed discussion to proceed without interruption. A staff member took brief notes during each session.

b. Nature and Use of the Information. Raw information was of two kinds: tapes of the sessions and the participants' written comments on the discussion guides. The tapes were transcribed verbatim and all names and personal references were deleted from the transcripts.

A codebook for information processing was based on the topics outlined in the discussion guide; each participant's written comments were coded accordingly. The information was then processed by computer, yielding summaries for each occupation and location. The transcripts, supplemented by the descriptions of participants summarized from coded written comments, were subjected to content analysis.

Since not all participants expressed themselves on all matters presented in the discussion guide, tabular materials based on transcriptions and written comments on the guides are presented in an appendix to the monograph for the purpose of interpreting trends, common attitudes, and differences among groups and are primarily suggestive rather than definitive. The

tables may be useful in generating hypotheses which can be tested on larger groups of women in a systematic manner.

2. Employment Benefits Study

Written information on benefits was requested from 703 general medical and surgical hospitals and 946 nursing homes in Georgia, Massachusetts, Minnesota, New Mexico, Ohio, Texas, and Washington. The hospitals and nursing homes were selected from the Master Facility Census of the National Center for Health Statistics (NCHS). One hundred fifty-five dental groups were contacted from the nationwide roster of 946 members of the American Academy of Dental Group Practice.

The employers included in the study were requested to submit any and all printed material on benefits and other personnel policies that they routinely provide to prospective and current employees. A checklist of common employment benefits was enclosed to indicate the kind of information needed.

The total number of checklists and brochures received from hospitals was 264, representing 189 hospitals. Nursing homes sent 146 checklists and brochures, representing 120 institutions. Seventy-four of the 155 dental groups sent checklists; nine also sent brochures. Some organizations, in addition to indicating employment benefits on the checklist, wrote comments or added details about the benefits they offer. The brochures usually contained specific information on a wide range of benefits. Because of differences in the kind of information obtainable from checklists and brochures, they were analyzed separately. A codebook was developed for each; the information was then processed by computer.

THE LIFE PATTERNING PROCESS

The concept which guided the research is the Life Patterning Process, a conceptual framework based on the hypothesis that, at graduation from secondary school, men and women are confronted with very different career choices. Men's choices are work and education; both focus on the need to earn a living and establish oneself to begin a lifetime of employment. For women, career options also include marriage; often, the decision to work or continue one's education is tempered by the expectation of eventual marriage. Once a man has established himself in an occupation or career, variations on it may occur but the goal usually remains the same -- to earn a living and, possibly, to support a family.

A woman's choices, on the other hand, tend to become increasingly complex. Some time after her initial career choice is made, she usually reaches a point at which change many occur. At this juncture, women who elected marriage following high school have very different options than those who

elected to continue their education. The former may seek employment, access to educational programs, or a combination of the two. Their options will be limited by the length of time between termination of secondary education and this second-level career choice; the longer the hiatus, the more limited the options. Women who continued their educations beyond high school have three different career choices: work, marriage, or a combination of the two. These women's work options will be more extensive than the other group's. While such a woman's job opportunities will be limited by the focus of her post-secondary education, her opportunities for employment will be greater than those of a woman who married immediately after high school. Furthermore, educational programs leading to advanced degrees tend to lead to a wider range of job options than do programs of limited length and focus. For example, a woman with an LPN degree has far fewer options than one trained as an RN or a high-status profession such as dentistry or medicine. Certain of the following conclusions about the participation of women in the health labor force are germane to various facets of the Life Patterning Process.

FINDINGS

A total of 279 women were included in the study: 60 licensed practical nurses, 72 registered nurses, 58 dental hygienists, 24 dentists and 65 health care administrators. The demographic and socioeconomic characteristics of the participants in this study largely correspond to those of most women in their occupational groups with respect to race/ethnicity, age and marital status. The participating registered nurses and dental hygienists tended to be more highly educated than is average for their occupations.

The median age of participants ranged from 31 for the dental hygienists to 49 for the licensed practical nurses. Over one-half of the participants were married, as are approximately 58 percent of the women in the total United States labor force[1]; over one-tenth were divorced, a proportion in excess of the estimate of one in twenty for all U.S. women. Average age at first marriage was in the early twenties for RNs, dental hygienists and health care administrators. Dentists tended to marry in their late twenties and LPNs generally married earliest, between the ages of 18 and 20.

A dual-role career pattern was the most prevalent among the participants in general. The dominant features of this pattern are high school graduation

1 U.S. Department of Commerce, Bureau of the Census, A Statistical Portrait of Women in the United States, Current Population Reports, Special Studies, Series p. 23, No. 58, 1976, Table 7-4.

basic occupational training, marriage and childbirth, and simultaneous childrearing and career building. In some cases, these activities were accompanied by study for an advanced degree. Women who never married and those who, though married, have no children and undemanding husbands tended to have career patterns analogous to men's.

The greatest differences observed were among occupational groups. Women in the higher-status, higher-paying occupations, such as dentistry and health administration, tended to have parental family backgrounds of higher socioeconomic status than did licensed practical nurses. However, factors related to childhood socialization, such as parental support of career goals, appeared to be a significant determinant of occupational choice.

A predominant theme of the group discussions was status-- both the status of the occupation within the health care hierarchy and the status of women within the occupation.

1. Licensed Practical Nurses. Licensed practical nursing is a low-status, low-paid occupation. While the number of LPNs is only slightly more than half that of registered nurses in the United States, the occupation's growth has been remarkable. According to employment projections, the number of registered nurses will increase by 40 percent between 1972 and 1985; by contrast, a 96 percent increase in the number of licensed practical nurses is expected.[2] Unlike registered nurses, little is known about LPNs' career aspirations, career ladders, and obstacles to career mobility.

Three major themes characterized the consultation sessions with licensed practical nurses. First, LPNs perceived their role as providing direct bedside patient care. Consequently, they tended not to seek administrative tasks while the converse is apparent with registered nurses, particularly those who are college trained. At times the LPNs were critical of the training provided to registered nurses in collegiate programs, claiming that such training is insufficient for patient care. The LPNs strongly desired greater recognition of their value as providers of clinical services. The professionalization of nursing was troubling to the LPNs, who fear that further stratification of registered nurses may cause the occupation of licensed practical nursing to be eliminated; such an outcome would, they argue, both reduce their opportunities for employment and have a deleterious effect on the quality of patient care.

Relative to the other groups studied, the LPNs tended to focus more exclusively on their immediate, day-to-day activities, including the delivery of patient services and family responsibilities. The fact that few LPNs belong to their national association may be construed as a lack of identification with the occupation; however, the group consultations attested to a strong identification with their role as providers of care.

2 U.S. Department of Labor, Employment Standards Administration, Women's Bureau, 1975 Handbook on Women Workers, Bulletin 297, p. 266.

2. Registered Nurses. The general tone of the consultations with registered nurses was very different. Patient care was discussed less frequently than by the LPNs. Instead, sessions tended to focus more often on power within the health system and the need for registered nurses to beome equal with physicians in the health team's decision-making process. It was a general theme of the RNs' remarks that their role is different from but equal to that of the physician and that they therefore merit equal recognition and recompense.

3. Dental Hygienists. Dental hygienists and dentists also are characterized by overlapping patient involvement but drastically different levels of professional status. Dental hygienists manifest a strong sense of pride in their occupation but are frustrated by their limited opportunities for advancement, which are usually restricted to teaching, administration and research within the field.

Job dissatisfaction was discussed most frequently in reference to private dental practice. The dentist usually has absolute power in the office; the dental hygienist thus has no control over her working conditions. Because most dentists are male, the terms of conflict between the hygienist and the dentist are often dictated by the relative power and perceived attitudes of the two sexes. Owing to the nature of most office practices and the part-time or unstructured hours many dental hygienists work, many are without employee benefits. Among the exploitative practices reported were blackballing of hygienists, sexual advances, unjustified salary cuts and arbitrary dismissals. Considerable concern was expressed about dentists' insufficient recognition of hygienists' financial contribution to the practice. The hygienists who do not receive a commission considered their wages inadequate in proportion to the income they produce and advocated commission fees as fairer than salaries.

Dental hygienists from large urban areas perceived oversupplies of trained hygienists in their locales, resulting in a buyers' market characterized by low wages and restricted job mobility. (It is noteworthy that dental hygiene is described by the Department of Labor as characterized by greater demand than supply, and thus by ample opportunities for both full- and part-time workers.[3] Though subjective, the comments of participating dental hygienists suggest a maldistribution of manpower in this occupational category.)

Criticism of dentists, though quite prevalent among hygienists, was tempered by acknowledgments that negative attitudes prevail only among a minority of dentists. According to participants, younger dentists demonstrate more respect and appreciation of the role of the dental hygienist. The participating hygienists also expressed considerable job satisfaction, particularly with regard to their freedom to control the

3 Ibid., p. 265.

number of hours they work and their relationships with patients. Many expressed satisfaction in exercising their training and skill in preventive dentistry.

4. Dentists. The relatively few women dentists who participated in the study presented themselves as strong individuals with clear-cut career goals. They tended to define themselves as pioneers whose perseverance enabled them to achieve success despite discrimination and whose duty it is to help other women pursue comparable success. A few of the dentists stated that they avoid activities, such as membership in the American Association of Women Dentists, which set them apart from their male colleagues. Their stated preference was to "stay in the mainstream" where they can serve as examples to both male dentists and younger women interested in dentistry. In general, the participants clearly felt that dentistry is an appropriate profession for women and were eager to promulgate that view.

5. Health Care Administrators. Of the five participating occupational groups, the health care administrators had the most varied backgrounds and appeared to be the most independent and self-confident. Their descriptions of their careers indicated confidence in their ability to make decisions and to grow professionally. As a group, they tended to define health administration as a conglomeration of jobs in which the highest-status positions are held by men. Professional credentials were perceived as equally important as "who and what you know" in the pursuit of upward mobility. While women often hold number-two positions, according to the participants, they are rarely welcomed into the top level of management. Furthermore, women's tenure in senior administrative positions is perceived as limited by male professionals' assumptions about women's financial acumen; the participants regarded the view that women are unable to handle large budgets as the major obstacle to their advancement. The participating health care administrators tended to attribute their own success to having won the respect and support of both peers and supervisors.

The five groups of women studied varied markedly in their senses of themselves, ability and desire to compete, and perceived ability to control their own advancement and job satisfaction. In general, the lower an occupation's status, the less self-confidence is expressed by its members. As might be expected, women in the higher-status positions expressed higher degrees of conflict with the male-dominated power structure. It is interesting to note that while dental hygienists, dentists, and health care administrators are struggling for gains within the existing male-dominated structure of health occupations, registered nurses are trying to generate a system of health care delivery parallel to and competitive with the physician-dominated system.

6. Factors in Original Career Choice. An inference can be drawn from the study's findings that socioeconomic class, reflected in parents' income and occupations, is related to daughter's occupational choice. Women from lower socioeconomic backgrounds tend to elect lower-status occupations; if both mother and father were professionals, the daughter was more likely to choose a higher-status health profession. The results of the study imply a strong relationship between the example set by the mother as role model and the daughter's career choice. It appears, on the basis of statements of some participants, that in families with limited financial resources, money is more often allocated to the sons' college educations than to the daughters'.

An important finding of this study is the perceived inadequacy of high school guidance counselors. Many of the participants considered teachers' and guidance counselors' attitudes to have been important factors in their initial choice of career; a number reported having been presented only two traditionally female career options: nursing and teaching. Cases were reported of teachers' and guidance counselors' active discouragement of a student aspiring to professions such as medicine and dentistry.

Overall, the most critical factor in the participants' initial career choices appeared to be parental attitudes. Women who eventually elected traditionally female occupations had often been encouraged to do so on the grounds that such work might lead to desirable marriages or serve to "fall back on." By contrast, the dentists reported strong support from their parents to enter their chosen field.

It can thus be hypothesized that, if sufficient economic resources are available, the most important variable in the selection of a high-status, traditionally male-dominated career is parental support and encouragement.

7. Factors in Secondary Career Choice. The group participants provided relatively little information regarding secondary career choices -- those made after the initial choice following high school graduation. It appears, however, that most belong to multicareer families and that the ability to combine employment, and possibly education, with homemaking is dependent on a supportive family structure. Much more work is needed to identify the factors in secondary career choice and to help women continue to define their career patterns satisfactorily after the initial choice has been made.

8. Career Options and Access to Training. Once a career or occupation has been selected, the adequacy of the training program influences the student's future ability to advance professionally. Most complaints in this area were from LPNs and RNs. Nursing programs were frequently criticized on the grounds that the curriculum bears relatively little relationship to the demands of nursing practice.

Many participants were currently pursuing further education in the interests of career development. A number of licensed practical nurses found it difficult to gain admission to nursing programs and faulted their training as inadequate for further education or for career advancement. Overall, the participants expressed many unmet expectations; the desire to enhance their career options through pragmatically focused courses or degree programs was widespread.

That education is a dominant factor in the participants' present lives and future plans is apparent in the large proportion who are currently students, have pursued continuing education, and/or express the need for additional training. According to a number of participants problems attendant on the pursuit of continuing education include: insufficient time off during the day to take the necessary courses; lack of reimbursement by the employer institutions; difficulty of access to necessary training programs; unavailability of desired courses in such fields as management; and uncertainty about educational requirements for occupational advancement. As continuing education becomes mandatory in nursing and other fields, the quality and accessibility of such programs become increasingly important.

The dentists reported the most overt discrimination with regard to training. In keeping with the findings of the recent report on the MOBVOPPP schools,[4] dentists reported sexist admissions policies at dental schools; once admitted, women dental students experience discrimination by faculty and male peers. The comments of participants in the other occupational groups suggest that they have suffered less from sexual discrimination than from the limited options available within female-stereotyped occupations. Movement from a female-dominated occupation such as dental hygiene, to a related male-dominated profession such as dentistry, is typically extremely difficult.

Resentment of affirmative action was expressed among both minorities and Caucasians. White students felt discriminated against by the current trend in favor of minorities. On the other hand, the attention focused on minority students accepted into a given program placed considerable pressure on them and tended to further isolate them from their fellow students.

4 Urban and Rural Systems Associates (URSA), An Exploratory Study of Women in the Health Professions Schools. Prepared for the Women's Action Program, Office of Special Concerns, Office of the Assistant Secretary for Planning and Evaluation, Department of Health, Education and Welfare, 1976.

9. Family and Child Care Responsibilities. Comments concerning family responsibilities and child care varied relatively little from one occupational group to another; the presence and ages of children are primary considerations for all women who work. About half the participants have at least one child, though many of their children are beyond the age of total dependence.

Satisfactory child care arrangements were overwhelmingly regarded as of critical importance; there seems to be a direct relationship between the perceived quality of care the children receive and the mother's degree of ambivalence about leaving them during the day to pursue a career. It is interesting to note that day care centers, which are less widely available at places of employment today than they were during World War II, were seldom used by the participants; LPNs and RNs were more likely than the other groups to look favorably on this form of child care. More widely employed arrangements included hiring a babysitter, leaving the children with one's husband or another relative, working only during school hours or at night, and combinations of the above. Provisions for preschool children, unsupervised teenagers, and sick children were among participants' most frequently expressed needs.

Social norms and psychological theories disapproving of working mothers have engendered feelings of doubt and anxiety, particularly among middle-class professional women. Participants tended to resolve such problems either by remaining at home while their children were young, or by rationalizing that their children's development is enhanced by contact with other adults. It is apparent that women who are trying to balance childrearing and careers need more help from the policy-making level of government.

A supportive husband was acknowledged by participants in all five occupational groups to be an asset in a married woman's career development and personal satisfaction. Nearly three in five women who commented on the subject stated that their husbands share household tasks. Married working women are making slow progress toward changing the traditional sexual division of labor within the family; however, participants' comments suggest that this process is costly in terms of personal energy and productivity.

10. Employment Benefits. The job benefits most frequently mentioned as important by the group participants were adequate salaries, opportunities for advancement, child care arrangements, financial assistance for continuing education, and flexible scheduling. Many also expressed a need for ongoing career counseling, available throughout one's working life.

The Employment Benefits Study was very limited in scope owing to its design, which depended on an analysis of brochures and check lists which were requested from a number of institutions and dental group practices.

Most participating institutions were found to provide sick pay, vacations, some form of health insurance, bereavement days, and holidays. Differences were found between hospitals and nursing homes and between facilities of different sizes. In general, hospitals provide their employees a better package of benefits than do nursing homes; the larger the facility, furthermore, the better the benefit package. These findings were not unexpected. Most outstanding among the benefits desired but currently unavailable are flexible scheduling, career counseling, and employer-provided day care. Maternity leave appears to provide less liberal benefits and be less widely available than military leave; loss of pay and benefits is also more frequently associated with the former than the latter.

Perhaps of greatest importance is the finding that benefit packages are often limited to full-time employees. Since working mothers often elect part-time employment, they tend to be excluded from basic employer-provided benefits.

GENERAL CONCLUSIONS

The participants in this study were self-selected; they were not chosen by means of random sampling procedures. Thus they cannot be considered representative of their occupational groups. Nevertheless, they do in many ways reflect the demographic, social, and educational characteristics of the occupational groups to which they belong. This report offers perceptions and opinions based on findings both richer and less quantifiable than the usual statistical results; its findings are based on the free oral and written expression of experiences, opinions, and attitudes in an informal setting. It is hoped that they will be hypothesis-generating for other researchers.

Though women constitute approximately three-fourths of the health care labor force, they wield little power in the health care system, are concentrated in low-status jobs remote from the loci of decision-making, and have limited opportunities for advancement even into middle-management positions. Very few women are represented in such prestigious health care professions as medicine and dentistry. While efforts are being made to increase the proportions of women in both fields (in some medical and dental schools, women currently account for over one-fourth of the student body), the impact of such efforts have not yet been felt in the health care industry.

Sex-stereotyping and frictional relationships with male professionals were major issues for women in all the occupational groups studied. For the licensed practical nurses, males posed a status threat in that they tended

to move into positions of power rapidly; registered nurses tended to perceive physicians and administrators as monopolizing power and status within the health care industry and as deprecating of nurses' competence and intellectual abilities. However, the traditional male-female relationship between physicians and nurses is firmly entrenched not only in the structure of the health care system but also in the education and socialization of nurses. Thus some participating registered nurses observed that other nurses often oppose or subvert their efforts to assert themselves and to enhance the power and position of nursing within the health care system.

Dental hygienists who work in private dental practices expressed considerable dissatisfaction at the virtually total control over their salaries and working conditions exercised by their dentist employers (who are usually male). If the dentist feels his practice is not producing enough income, the hygienist may be let go; the dental assistant can assume some of the hygienist's duties. Fringe benefits taken for granted by most workers-- such as vacations and sick pay-- are rare for hygienists in private pratice.

Participating dentists tended to differ by age in their perceptions of their treatment within the profession. Older dentists often denied having problems with their male colleagues and tended to minimize or rationalize friction. Many dentists reported experiences during their training that can only be characterized as discrimination or putdowns. Younger participants, tended to recognize such putdowns for what they were but to shrug them off.

Of all the participating occupational groups, health care administrators compete with men most directly and on the most equal footing; nevertheless, they perceive themselves as likely to be second-choice for highly desirable positions. The need for a male mentor in order to be successful was widely noted by this group.

The most noteworthy finding of the study regarding women and careers is that women in health occupations are increasingly combining a career with marriage and a family. Very few of the participants delayed their careers because of children; in fact, many continued to work throughout their pregnancies and took relatively short maternity leaves. This pattern is particularly prevalent in the higher-paying occupations. Policymakers need to be cognizant of this changing pattern, which differs markedly from prevailing social norms and expectations.

RECOMMENDATIONS

1. Many participants noted the benefits to them of the group consultations, affirming that it is stimulating, useful, and potentially productive to meet with one's counterparts to compare experiences, explore common interests and discuss issues of shared concern. In effect the sessions provided participants opportunities to form informal local occupational networks and support systems. Research into the group consultations' effects on the formation and/or strengthening of such networks should be undertaken at the earliest date. The following questions ought to be considered:

   a. Did the meetings have any impact on the participants' perceptions of themselves or of their occupations?
   b. Were occupational or social networks initiated or strengthened?
   c. Did the participants "learn" anything?

2. During employees' working lives, the educational process proceeds formally and informally until employment is terminated. The contribution of formal continuing education to the maintenance of a highly trained labor force is attested to by the growing number of states that are legislating mandatory continuing education. Nevertheless, most universities that offer continuing education programs treat them as distinct from the mainstream curriculum. Thus continuing education instructors are offered little incentive or reward other than financial remuneration. Courses are often developed haphazardly, on the basis of the individual instructor's interests; rarely do they involve an evaluation component. It is recommended that national policy be developed with regard to continuing education for health care employees. Curricula should be developed in light of the needs of the community and specific occupational groups; quality control measures should be required. High priority ought to be given to courses designed specifically to meet the needs of women who are advancing or wish to advance in their careers. Many successful nurses, for example, find themselves in administrative positions without having had adequate management training. It is further recommended that projects be funded to develop and test educational modules that provide for the needs of women in specific health occupations. Such modules could then be distributed through regional Office of Health Resources Opportunity offices.

3. The observations of this study suggest that, disregarding the socioeconomic status of the parental family, the attitudes of parents and guidance counselors during the junior high and high school years are strong determinants of career choice. Counselors' negative attitudes toward given occupations appear to have been more significant than were supportive attitudes as determinants of the participants' career choices. It is recommended that

intensive efforts be undertaken to improve the quality of counseling at the junior high and high school levels and that research be designed to test the efficacy of various forms of career counseling. All career counseling programs at these levels should include projects and/or activities designed to enhance parental awareness of career options for women. Whenever possible, parents and high school counselors should be provided opportunities to visit a variety of health care institutions and to talk with working women and men in various health occupations. Such opportunities should be designed to expand parents' awareness of career options in the health field and of the importance of their role in supporting a student's career choice.

4. The work initiated through this project should be pursued further, with particular emphasis on (a) career choice and (b) those factors in health-related work experience and environment that allow and/or aid women to advance professionally. Such a study or studies should include further exploration of the relationship between socioeconomic background and career choice.

5. An eventual reduction in the total population available for the labor force appears to be likely, owing to the stabilization of population growth. Of various potential future work patterns, flexible scheduling is a particularly attractive proposal. Unlike in industry, little or no investigation has been done into the impact of flexible scheduling on hospitals. It is recommended that one or more demonstration projects be funded to test the applicability of flexible work scheduling to the health care environment. Specific attention should be given to the impact of flexible schedules on employee satisfaction and cost containment. At least one such project ought to pertain to a seven-day hospital schedule.

6. It is recommended that one or more projects be funded to design, develop, and test an ideal mix of support systems for career advancement within a single or several related institutions. Such a project should be characterized by a financial assistance program, career counseling, leadership training, continuing education courses, flexible scheduling, and child care options. Provisions should be made for evaluation of the effectiveness of each component. The role of participants in decision-making procedures should be monitored and treated as an important indicator of institutional commitment to the project.

7. It is recommended that national health policy bearing on women employees in the health industries be studied by responsible groups representative of women's interests. Health manpower legislation, cost control legislation, and occupational health and safety legislation should be examined for effects on the delivery of health services. Proposals for new legislation in at least these areas should be studied by policy analysis groups; final reports

should be presented as testimony before the appropriate legislative committees. Such reports should also be made available in printed form to the general public.

8. It is recommended that the mandate of the Office of Health Resources Opportunity be expanded to allow for review and comment on all federal programs and projects pertinent to the needs of specific categories of female health care employees. In this capacity, OHRO should be provided a fiscal base adequate to secure the necessary technical expertise; it should also be enabled to support projects such as those outlined above and others designed to meet the objectives of the Office.

Reducing costs, improving the quality of health care, humanizing the delivery of health services, and expanding services into areas of greatest need are not problems policymakers alone can solve. They must also be addressed by individuals working together at the local level. All too often, policymakers frame legislation without regard for its impact on those who must implement it at the local level. It is crucial to familiarize policymakers and link their activities with the realities confronted by those involved in the direct delivery of health services; to this end, it is necessary to understand fully the labor-force behavior and employment-related needs of women attracted to specific health occupations.